2008

Medical Plan

Information

ANNUAL SCHEDULE OF BENEFITS

MEDICAL PLAN

Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315
www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2200
www.newwesthealth.com

Peak Health Plan • 1-866-368-7325
www.healthinfonetmt.com

MEDICAL RATES

Monthly and Per Paycheck Premiums

	Traditional	Blue Choice	Peak	New West
Employee	$557/$279	$466/$233	$524/$262	$444/$222
Employee & spouse	$762/$381	$630/$315	$722/$361	$618/$309
Employee & children	$662/$331	$550/$275	$630/$315	$538/$269
Employee & family	$776/$388	$642/$321	$734/$367	$628/$314
Joint Core	$598/$299	$498/$249	$570/$285	$488/$244

MEDICAL PLAN COSTS

Annual Deductible
(Applies to all services unless noted or a co-payment is indicated)

Coinsurance Percentages (% of allowed charges member pays)
General
Preferred Facility Services *(See pages 37-38 for a list of preferred facilities)*
Nonpreferred Facility Services *(See page 37 for a list of non-preferred facilities)*

Annual Out-of-Pocket Maximums
(Maximum coinsurance paid in the year; excludes deductibles and copayments)

You pay deductible and coinsurance on allowable charges (see glossary on page 6).

MEDICAL PLAN COSTS

Hospital Inpatient Services*

Pre-certification of non-emergency hospitalization is strongly recommended & required by some plans - see plan descriptions

Room Charges

Ancillary Services*

Surgical Services*

Hospital Outpatient and Surgical Center Services*

BENEFIT YEAR 2008

NON-MEDICARE MEDICAL RATES (under age 65)

Monthly Premiums	Traditional	Blue Choice	Peak	New West
Retiree	$557	$466	$524	$444
Retiree & spouse	$762	$630	$722	$618
Retiree & children	$662	$550	$630	$538
Retiree & family	$776	$642	$734	$628
Retiree & Medicare spouse	$652	$542	$620	$532
Retiree & Medicare spouse and child	$680	$564	$646	$554

MEDICARE MEDICAL RATES (age 65+)

Monthly Premiums	Traditional	Blue Choice	Peak	New West
Medicare retiree	$194	$172	$188	$160
Medicare retiree & spouse	$408	$344	$394	$340
Medicare retiree & children	$346	$294	$338	$292
Medicare retiree & family	$430	$362	$414	$358
Medicare retiree & Medicare spouse	$358	$304	$348	$300
Medicare retiree & Medicare spouse & family	$386	$328	$374	$322

TRADITIONAL PLAN Administered by BCBS of MT	MANAGED CARE BENEFIT PLANS BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan PEAK - Administered by Peak Health Plan	
Benefits	**In-Network Benefits**	**Out-of-Network Benefits**
$550/Member $1,650/Family	$400/Member $800/Family	Separate $500/Member Separate $1,000/Family
25% 20% 35%	25%	35%
Average of $2,500/Member *(20% - 35% of $10,000 in allowable charges)* Average of $5,000/Family *(20% - 35% of $20,000 in allowable charges)*	$2,000/Member $4,000/Family	Separate $2,000/Member Separate $4,000/Family
Member Coinsurance:	**Member Coinsurance/Copayment:**	**Member Coinsurance:**
20% - 35%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%

ANNUAL SCHEDULE OF BENEFITS

MEDICAL PLAN SERVICES

Physician/Professional Services (not listed elsewhere)

Office Visits

Inpatient Physician Services*

Lab/Ancillary/Injectibles/Miscellaneous Charges*

Emergency Services

Ambulance Services for Medical Emergency

Emergency Room *(If there is an inpatient emergency admission, see plan description for authorizing follow up care.)*

Hospital Charges

Professional/Ancillary Charges

Urgent Care Services

Facility/Professional Charges

Ancillary - Lab & Diagnostic Charges

Maternity Services

Hospital Charges*

Physician Charges (including delivery, pre and post-natal office visits) and lab charges*

Ultrasounds*

Routine Newborn Care

Inpatient Hospital Charges

Preventive Services (see plan descriptions for what services are covered and when)

Adult Exams and Tests

Adult Immunizations (such as Pneumonia and Flu)

Allergy Shots

Child Checkups and Immunizations

Mental Health Services

Inpatient Services*

Max: One inpatient day may be exchanged for two partial hospital days.

Outpatient Services

With EAP counselor referral

With NO EAP counselor referral

BENEFIT YEAR 2008

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
25% (no deductible for first two non-routine office visits)	$15/visit (covers professional charges only)	35%
25%	25%	35%
25%	25% (no deductible on injectibles without an office visit)	35%
25%	$100 copay	$100 copay
20%-35%	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)
25%	25%	25%
25%	$25/visit	$25/visit
25%	25%	35%
20% - 35%	25%	35%
25%	0% if member enrolls in a prenatal program in first trimester of pregnancy; 25% without timely enrollment	35%
25%	25% (waived on first ultrasound if member enrolls in prenatal program as described above)	35%
20% - 35% (no deductible)	25% (no deductible)	35%
25% (no deductible) **Max**: 2 bone density tests/lifetime **Max**: $500 for colonoscopy, sigmoidoscopy, or proctoscopy	$15/visit (including specified labs) 0% (no deductible) for periodic mammograms 25% for periodic bone density scans, EKG sigmoidoscopies, double contrast barium, enemas, proctoscopies & colonoscopies	35% (plan pays $75.00 for periodic mammograms - no deductible)
$50 Max (no deductible)	$15 with office visit 25% (no deductible) without office visit up to $10	35%
25% (no deductible)	$15 with office visit 25% (no deductible) without office visit up to $10	35%
25% (no deductible) 0% (no deductible for County Health Department through age 7)	$15/visit **Max**: Schedule recommended by US Department of Health & Human Services	35%
20% - 35% **Max:** 21 days *(No max for severe conditions)*	25% **Max:** 21 days/yr *(No max for severe conditions)*	35% **Max:** 21 days/yr *(No max for severe conditions)*
25% **Max**: 40 visits/yr *(No max for severe conditions)*	$15/visit **Max**: 30 visits/yr *(No max for severe conditions)*	35% **Max**: 30 visits/yr *(No max for severe conditions)*
50% **Max**: 20 visits/yr *(No max for severe conditions)*	$15/visit **Max**: 30 visits/yr *(No max for severe conditions)*	35% **Max**: 30 visits/yr *(No max for severe conditions)*

ANNUAL SCHEDULE OF BENEFITS

MEDICAL PLAN SERVICES

Chemical Dependency Services

Inpatient Services*
(Inpatient services must be certified. Pre-certification is strongly recommended.)

Outpatient Services*

With EAP counselor referral

With NO EAP counselor referral

**Dollar max for all Chemical Dependency Services: Combined inpatient/outpatient max of $6,000/year; $12,000/lifetime; $2,000/year after max is met.

Rehabilitative Services - Physical, Occupational, Cardiac, Pulmonary, and Speech Therapy*

Inpatient Services*

Outpatient Services

Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

Extended Care Services

Home Health Care*

Hospice*

Skilled Nursing*

Miscellaneous Services

Disease Process Education & Dietary/Nutritional Counseling

Durable Medical Equipment, Appliances, and Orthotics* *(Prior authorization required for amounts >$1,000)*

PKU Supplies

Obesity Management* *(All plans require prior authorization)*

TMJ Treatment* *(All plans require prior authorization)*

Infertility Treatment* *(All plans require prior authorization)*

Bariatric Benefit* *(see page 14 for more details - requires prior authorization)*

Organ Transplants *(Must be certified. Pre-certification is strongly recommended.)*

Transplant Services (including out-of-state travel)*

BENEFIT YEAR 2008

	TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
	20%-35% **Max:** Dollar Limit**	25% **Max:** Dollar Limit**	35% **Max:** Dollar Limit**
	25% **Max**: 40 visits and Dollar Limit**	$15/visit **Max**: Dollar Limit**	35% **Max**: Dollar Limit**
	50% **Max**: 20 visits and Dollar Limit**	$15/visit **Max**: Dollar Limit**	35% **Max**: Dollar Limit**
	20% - 35% **Max**: 60 days/yr	25% **Max**: 60 days/yr	35% **Max**: 60 days/yr
	20% - 35% **Max**: $2,000/year for all outpatient ($10,000/year for prior-auth. conditions)	$15/visit **Max**: 30 visits/yr	35% **Max**: 30 visits/yr
	25% (plus charges over $30/visit)	Not covered	Not covered
	25% (plus charges over $30/visit)	Not covered	Not covered
	25% (plus charges over $30/visit) **Max**: 25 visits in any combination	$15/visit **Max**: 20 visits/yr	35% **Max**: 20 visits/yr
	25% **Max**: 70 days/yr	$15/visit **Max**: 30 visits/yr	35% **Max**: 30 visits/yr
	25% (20% - 35% if hospital-based) **Max**: 6 months	25% **Max**: 6 months	35% **Max**: 6 months
	25% (20% - 35% if hospital-based) **Max**: 70 days/yr	25% **Max**: 30 days/yr	35% **Max**: 30 days/yr
	20% - 35% **Max**: $250/yr	0% (no deductible) **Max:** $250/yr	35% **Max:** $250/yr
	25% **Max**: $100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) **Max**: $100 for foot orthotics (per foot)	35% (not applied to out-of-pocket max) **Max**: $100 for foot orthotics (per foot)
	25%	25% (no deductible)	35%
	25%	25% non-surgical only	Not covered
	25%	25% surgical only	Not covered
	25% 1 in-vitro attempt per lifetime	25% Max: 3 artificial inseminations/lifetime	Not covered
	25% **Lifetime Max**: $35,000	Not covered	Not covered
	25% • Liver: $200,000 • Heart: $120,000 • Lung: $160,000 • Heart/Lung: $160,000 • Bone Marrow: $160,000 • Pancreas: $68,000 • Cornea/Kidney: No maximum	25% $500,000 lifetime maximum with $5,000 of the maximum available for travel to and from the facility.	Not covered

MEDICAL INSURANCE PLANS - 2008

Administered by:
Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315 • www.bluecrossmontana.com
New West Health Plan • 1-800-290-3657 or 457-2200 • www.newwesthealth.com
Peak Health • 1-866-368-7325 • www.healthinfonetmt.com

WHO IS ELIGIBLE?

Employees, Legislators, Retirees, COBRA members and their dependents (spouse, domestic partner, children) of the State Benefit Plan are eligible for the Medical Insurance Plan. Employees are required to be enrolled in medical coverage unless they waive the entire benefit package. For more information about dependent eligibility, see page 16.

CLICK ON IT!

Learn more about the participating providers by visiting the plan's web sites at:

www.bluecrossmontana.com

www.newwesthealth.com

www.healthinfonetmt.com

HOW TO DECIDE THE RIGHT PLAN FOR YOU

1. Read about each plan in the General Information section on this page.
2. Review/compare each plan's costs, deductibles and services in the Schedule of Benefits starting on page 8 or through the SOME information resouce availabe on the MINE.
3. Review your typical health care needs compared with the structure of the plans.
4. If you are considering a managed care plan, review the Managed Care Areas section on pages 34-36.
5. Determine which plan will work best for your personal situation.
6. If you choose to change plans for the 2008 benefit year, indicate your choice on the *Individual Benefit Statement* or on-line as indicated on page 5.

GENERAL INFORMATION

The State of Montana offers an indemnity insurance plan and three managed care plans to choose from:

- **Traditional Indemnity Plan**
- **Blue Choice**
- **New West Health Plan**
- **Peak Health Plan**

LIFETIME MAXIMUM INCREASED

New

Beginning January 1, 2008, the lifetime maximum (the maximum the plan pays) per person on the plan increases from $1 million to $2 million.

TRADITIONAL PLAN

The Traditional indemnity plan is administered by Blue Cross and Blue Shield of Montana (BCBS), which processes claims and payments, provides customer service and notice to members in the form of an Explanation of Benefits (EOB). BCBS also contracts with health care providers to offer plan members a provider network – providers who have agreed to accept certain plan allowances.

How The Plan Works

Plan members obtain medical services from a covered health care provider. If the provider is a BCBS provider, he or she will submit a claim for the plan member. BCBS will then process the claim and send an EOB to the plan member, indicating their payment responsibilities (deductible and/or coinsurance costs) to the provider. The Plan then pays the remaining allowable charges, which the provider accepts as full payment. Please verify a provider is currently participating by calling BCBS or checking their website.

If the provider is not a BCBS provider, you may be required to pay the entire fee and file a claim for reimbursement. There may be unallowed charges which you will have to pay.

Bariatric Benefit

New

This benefit is available only on the Traditional plan. In order to qualify, you must be on the State plan for 18 months, have a body mass index over 40, and participate in the health screening and *Why Weight* programs (page 26). For cost information, see pages 12 & 13.

Preferred Facility Services

Plan members may obtain covered medical services from any covered hospital. However, certain hospitals and surgical centers offer services for members on the Traditional plan that are subject to lower coinsurance rates. Please refer to the Participating Facilities section on page 37 for a list of these facilities. For your protection, it is strongly recommended to pre-certify all inpatient hospital services by calling your plan's customer service phone number, listed at the top of this page.

Out-of-State Services

The Blue Card Program lets plan members tap into BCBS plan networks in other states. If the out-of-state BCBS plan includes "hold harmless" provisions, the member will not be responsible for balances above the allowable amount.

MANAGED CARE PLANS

Blue Choice, New West Health Plan, and Peak Health Plan are managed care plans offered through the Montana Association of Health Care Purchasers, a purchasing pool of which the State is a member. The plans generally provide the same package of benefits, but there are differences in costs, providers and requirements for receiving services.

How They Work

The benefits of managed care plans depend on the health care provider the member uses. When a network provider is used, the in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply (unless a required referral/authorization is obtained).

In-Network Benefits

Anytime a network provider is used, the in-network (highest level of benefit) is applied. For a complete listing of all in-network providers including specialists, check the plan administrator's website or call their Customer Service number. A referral/authorization is not required for the plan member to see an in-network specialist. Referrals/authorizations **are** required to see an out-of-network specialist and still receive the plan's in-network benefits.

Out-of-Network Benefits

When plan members obtain services from providers who are not part of the plan's network, with no required referral/authorization, costs will be more because a separate and higher deductible, a higher coinsurance rate, and a separate out-of-pocket maximum apply.

Major Plan Differences

The major difference in the managed care plans are the participating providers and the process for referrals/authorizations.

Check which providers participate by visiting the plan websites listed on page 14. To obtain an authorization to see an out-of-network provider from the New West plan, the member must contact New West directly.

Referrals for the Blue Choice and Peak Health plans are obtained through your Primary Care Provider.

Out-of-State Services

Plan members may receive in-network benefits for medical services in other states for a medical emergency. For non-emergency services out-of-state, please contact your plan administrator for specific provider network information.

SERVICE AREAS

The Traditional Plan is available to members living anywhere in Montana or throughout the world. The plan includes services of any covered providers. However, providers who are not BCBS member providers may charge more for a service than the plan allows, leaving you responsible for paying the difference.

The managed care plans – Blue Choice, New West Health Plan, and Peak Health Plan – are available to members living in certain areas in Montana. Please see pages 34-36 for a complete listing of covered zip codes for each plan.

Blue Choice

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, and Havre.

New West Health Plan

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, Havre, Libby, and Miles City.

Peak Health Plan

This plan is available to members in Billings, Butte, Deer Lodge, and nearby communities.

MEDICAL PLAN COST COMPARISONS

This cost comparison shows how each medical plan would process the same service and what costs the plan member would be responsible for paying. The example is **cumulative** with respect to deductibles and coinsurance. The first line of each example shows the total costs to the member. The next three lines show how that cost is divided between copays, costs applied to the deductible, and coinsurance costs. It does not include premium costs, which are outlined on pages 8 and 9. These examples assume the services were for one member. This is simply an example for ease of plan comparison and is not a guarantee that similar services will process identically.

		TRADITIONAL	MANAGED CARE PLANS	
Sample Services	**Allowable Charge**		**In-Network**	**Out-of-Network**
Office visits 1, 2, & 3 ($50 each)	**$150 You pay ➡**	**$75**	**$45**	**$150**
Copay costs			$45 ($15/each)	
Costs applied to deductible		$50*		$150
Coinsurance costs		$25		
Lab charges with office visit 1	**$75 You pay ➡**	**$75**	**$75**	**$75**
Copay costs				
Costs applied to deductible		$75	$75	$75
Coinsurance costs				
Specialist Visit (i.e. dermatologist)	**$200 You pay ➡**	**$200**	**$15**	**$200**
Copay costs			$15	
Costs applied to deductible		$200		$200
Coinsurance costs				
Preferred hospital inpatient	**$8,500 You pay ➡**	**$1,880**	**$2,368.75**	**$3,023.75**
Copay costs				
Costs applied to deductible		$225	$325	$75
Coinsurance costs		$1,655	$2,043.75	$2,948.75
OR				
Nonpreferred hospital inpatient	**$8,500 You pay ➡**	**$3,121.25**	**N/A**	**N/A**
Copay costs				
Costs applied to deductible		$225		
Coinsurance costs		$2,896.25		

*First two office visits are exempt from the deductible for this comparison.